

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 011437	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/27/2016
NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL NORTH		STREET ADDRESS, CITY, STATE, ZIP CODE 7150 CLEARVISTA DR INDIANAPOLIS, IN 46256		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for the investigation of one state complaint.</p> <p>Complaint Number: IN00180115</p> <p>Substantiated, no deficiencies related to the allegations are cited.</p> <p>Date of Survey: 4-26-17 and 4-27-16</p> <p>Facility Number: 011437</p> <p>Community Hospital North is in compliance with 410 IAC 15-1.5-10, Utilization review and discharge planning services, Hospital Licensure rules.</p> <p>QA: 5/23/16 jlh</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE